

Provider Payment Glossary

A Guide for Medicaid Programs

For the information of Medicaid programs, we have prepared this Provider Payment Glossary with particular reference to Medicaid issues. We can help Medicaid programs with the design, implementation and maintenance of payment methods for services provided by hospitals, physicians and other providers.

Eight Basic Provider Payment Methods

Provider payment methods may be divided into eight basic methods, depending on the unit of payment.* Each method is characterized by a different division of risk between the payer and the provider (see the chart on the following page.)

In increasing order of payer risk, the eight basic methods are:

1. Per dollar of charges. The provider is paid a percentage of its charges, usually less than 100 percent. This method was previously common, but now most states typically reserve it for uncommon services.

2. Per dollar of cost. (Also called cost reimbursement.) The provider is reimbursed for the cost of the care it provides. The percentage is usually, but not always, 100 percent. Cost usually is determined only after the fact, so the provider receives an interim payment at a percentage of its charges. During a cost settlement process, provider cost reports are audited, and adjustments are made to payments as necessary. This method is often used by Medicare and Medicaid to pay critical access hospitals.

3. Per service. (Also called fee-for-service.) This method commonly involves fee schedules for drugs, physician services, durable medical equipment and dental care. The payer bears the financial risk for the number of services provided. The provider is at risk for the cost per service.

4. Per day. (Also called per diem payment.) Payment is per day of care; this method is commonly used by states to pay for nursing facility care. The payer is at risk for the number of days of care. The provider is at risk for the number and cost of services per day.

5. Per episode. (Also known as case rates.) The payer makes one payment for all care during a single episode of illness. Examples are paying hospitals using DRGs and paying surgeons for all care provided within a global period of 10 or 90 days.

6. Per recipient. (Also known as contact capitation.) The payer pays the provider a fixed amount per person once an eligible person has begun to use services. This method is uncommon, but it is sometimes used to pay specialist physicians.

7. Per eligible person. (Also known as capitation.) The payer pays the provider a per-person amount for each person eligible for services, regardless of whether the eligible person uses services. This method is commonly used by states to pay managed care plans.

8. Per time period. (Also known as budget.) The payer allocates a fixed dollar amount to a provider for a given time period. This method, simply an annual budget, is often used by states to pay the state psychiatric hospital.

In the example, total charges for inpatient hospital care for 1,000 people equals \$324,000. That amount can be divided into eight financial risk factors. The time period is one year. While 1,000 people are eligible for care, only 100 of them actually receive care. On average, those 100 people have two inpatient stays (episodes of care) per year, with an average length of stay of three days. On average, six services are received per day at an average cost of \$60 per service. The average hospital sets its charges at 1.5 times cost.

How the Eight Basic Payment Methods Divide Financial Risk Between Payer (Dark Blue) and Provider (Light Blue)

Example: total charges of \$324,000 =	1 year	x 1,000	x 10%	x 2	x 3	x 6	x \$60	x 1.5
1. Percentage of charges	●	●	●	●	●	●	●	●
2. Per dollar of cost	●	●	●	●	●	●	●	●
3. Per service	●	●	●	●	●	●	●	●
4. Per day	●	●	●	●	●	●	●	●
5. Per episode	●	●	●	●	●	●	●	●
6. Per recipient	●	●	●	●	●	●	●	●
7. Per eligible person	●	●	●	●	●	●	●	●
8. Per time period	●	●	●	●	●	●	●	●

Casemix Grouping Algorithms

An increasing number of payment methods include adjustment for the patient’s clinical characteristics. The goal is to place patients into groups, with providers receiving a fixed payment rate for each group but more payment for higher casemix groups. Providers then have incentives both to be efficient and to treat patients of all case mix groups. ACGs – Adjusted Clinical Groups®. (Formerly Ambulatory Care Groups.) A commonly used algorithm applicable to either capitation or per-recipient payment methods developed by researchers at The Johns Hopkins University School of Hygiene and Public Health. Each individual is assigned to a single ACG based on age, sex and diagnoses. It is typically based on one year’s worth of data. (For more information: www.acg.jhsph.edu.) APCs – Ambulatory Payment Classification Group. The Medicare payment method for outpatient hospital services, implemented in 2000. Other payers are also implementing or considering APCs. Multiple APCs may be assigned to a single outpatient visit, but not every service is assigned to an APC. Thus, the method is a blend of the basic per-diem and fee schedule approaches. CDPS – Chronic Illness and Disability Payment System. Designed for Medicaid programs to use in capitation payment methods. Individuals are assigned to one of 57 groups based on diagnosis, with additional subdivisions by age and eligibility status. (For more information: cdps.ucsd.edu.)

ACGs – Adjusted Clinical Groups®. (Formerly Ambulatory Care Groups.) A commonly used algorithm applicable to either capitation or per-recipient payment methods developed by researchers at The Johns Hopkins University School of Hygiene and Public Health. Each individual is assigned to a single ACG based on age, sex and diagnoses.

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DCGs – Diagnostic Cost Groups. Available in several variations. Can be used in either capitation or per-recipient payment methods. Medicare uses a variant called CMS-Hierarchical Condition Categories (HCCs) to calculate payments to health plans in the Medicare Advantage program.

DRGs – Diagnosis Related Groups. Each inpatient stay is assigned to a single DRG based on the patient’s diagnoses and the procedures performed. A relative weight is assigned to each DRG, and then multiplied by a “base price” to determine the amount paid to the hospital. Subsets include:

- **CMS-DRGs –** The first major casemix grouper; used by Medicare from 1983 until 2007.
- **MS-DRGs –** Medicare Severity DRGs. In use by Medicare since October 2007. A more sophisticated algorithm than CMS-DRGs, with more-accurate capture of comorbidities and complications. Not suited to a Medicaid population.

- **All-Patient Diagnosis Related Groups** – Previously used by a half-dozen states; now in use by only one. APR-DRGs were a refinement of AP-DRGs.
- **APR-DRGs** – All-Patient Refined Diagnosis Groups. Developed by 3M Health Information Systems. These are increasingly used by Medicaid programs. There are four levels of severity for each of the 314 DRGs in the system.

EAPGs – Enhanced Ambulatory Patient Groups. Initially called APGs. Developed for Medicare by 3M Health Information Systems as the possible basis for a prospective payment method for outpatient hospital services. However, Medicare implemented a variant of APGs called APCs. In 2007, 3M made significant changes to the Ambulatory Patient Groups to reflect current coding and billing practices and to describe a broader, non-Medicare population. The resulting product of these revisions is the Enhanced APGs (EAPGs).

HHRGs – Home Health Resource Groups. Medicare pays home health agencies per 60-day episode of care, with rates adjusted for casemix using HHRGs. Each patient is assigned to an HHRG based on results from the Outcome and Assessment Information Set (OASIS), which measures functional status. Inpatient Rehabilitation Groups. Medicare pays inpatient rehabilitation facilities per stay (i.e., per episode), with the rates adjusted for casemix using 92 groups. Each patient is assigned to a single group, based on results from the Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI).

RUG-IV – Resource Utilization Groups. Medicare and some Medicaid plans pay nursing facilities per diem, with rates adjusted for casemix using RUG-IV. Most Medicaid programs use a grouper with 48 RUGs. Data to assign each patient to a RUG come from the Minimum Data Set, an assessment of a patient's functional status. A few Medicaid programs still use the older version, RUG-III.

CRGs – Clinical Risk Groups. A capitation-based payment method developed by 3M Health Information Systems that uses a claims-based classification system that helps to predict an individual's healthcare utilization and costs on a prospective and retrospective basis. CRGs analyze clinical history and demographic characteristics to assign an individual to a severity-adjusted risk group.

PFEs – Patient-Focused Episodes. A per episode-based payment method developed by 3M Health Information Systems that calculates actual costs and expected resource utilization for more than 500 episodes that span inpatient and outpatient encounters. PFEs group all of a patient's claims during a specific period and assign the patient an event-based episode.

Diagnosis Coding Systems

Casemix Grouping Algorithms – especially more elaborate ones – depend on diagnosis, procedure and functional status data. These diagnosis coding systems are:

DSM-5 – Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. A classification system of only psychiatric and mental disorders. This manual includes diagnostic criteria for making each diagnosis. Not commonly used in casemix groups.

ICD-10-CM – International Classification of Diseases, Tenth Revision, Clinical Modification. A classification system of diseases, injuries and medical conditions, developed by the World Health Organization. It is a U.S. variant maintained by the National Center for Health Statistics, which revises the codes each October 1. These diagnosis codes are almost always required on healthcare claims. ICD-10-CM replaced ICD-9-CM on October 1, 2015. ICD-10-CM codes are alphanumeric instead of numeric and much more refined than ICD-9-CM codes.

Procedure Coding Systems

CPT-4 – Current Procedural Terminology, Fourth Edition. A five-digit numeric coding system of procedures and services provided to patients, usually by physicians. It also includes a series of two-digit modifiers. The American Medical Association updates the CPT-4 each January 1. It is widely used on professional claims and outpatient institutional claims.

HCPCS – Healthcare Common Procedure Coding System. A standard set of five-digit codes for medical services and procedures, as well as durable medical goods, ambulance services, medical supplies, dental procedures, orthotics, prosthetics and drugs. There are three levels of HCPCS codes: Level I is the CPT-4; Level II is described below; Level III refers to local codes. HCPCS Level II. This subset of HCPCS codes describes some physician services, but mostly consists of codes for durable medical goods, ambulance, medical supplies, dental procedures, orthotics, prosthetics and drugs. Codes are updated quarterly by CMS. When reference is made to "HCPCS," it is usually to HCPCS Level II.

ICD-10-PCS – International Classification of Diseases and Related Health Problems, Tenth Revision, Procedure Classification System. While the ICD-10 system classifies only diagnoses, the American ICD-10-PCS variant also includes procedures. The procedure classification is maintained by CMS and revised each October 1. Codes are in a 3–7 digit alphanumeric format. ICD-10-PCS was implemented in October 1, 2015.

Local codes. These were five-digit codes developed by each state and usually approved by Medicare for use in that state. They started with W, X, Y or Z. Under HIPAA, local codes were no longer allowed as of October 16, 2003, but remain in use in some states.

CDT – Current Dental Terminology. Published periodically by the American Dental Association.

NDC – National Drug Code. An 11-digit number used to identify a specific vendor and formulation of each drug. The NDC list is at www.fda.gov/cder/ndc.

Claim Formats

UB-04. The paper universal billing claim form used by hospitals, home health agencies, rural health clinics, federally qualified health centers and Indian health centers to bill insurance companies for their services. Maintained by the National Uniform Billing Committee (www.nubc.org), coordinated by the American Hospital Association. For electronic submission of institutional claims, the standard is the 837i.

CMS 1500. The paper claim form used by most professional providers, including physicians, physical therapists, medical supply providers, surgery centers, etc., to bill for their services. Maintained by the National Uniform Claim Committee (www.nucc.org), chaired by the American Medical Association. For electronic submission of institutional claims, the standard is the 837P.

ADA form. Paper claim form typically used to bill for dental services. Maintained by the American Dental Association.

837I, 837P, 837D. Formats for submitting institutional, professional and dental claims information in electronic form. Developed by the American National Standards Institute. The professional claim format, for example, is properly known as the ANSI ASC X12N 837P. Under HIPAA, all claims submitted electronically were required to follow the 837 format effective October 1, 2003.

Fee Schedule Approaches

RBRVS – Resource-Based Relative Value Scale. The most common physician fee schedule. Implemented by Medicare in 1992, now widely used by Medicaid, workers' compensation plans and private payers. A "relative value" is assigned to a CPT or HCPCS code that reflects the work effort, practice expense and malpractice expense for that service. The relative value is multiplied by a conversion factor dollar amount to determine the fee paid to the practitioner.

RVP – Relative Values for Physicians. Similar to the RBRVS. Also based on relative units assigned by time, training, skill and resources. Developed by Relative Value Studies, Inc. Used by some states and insurance carriers.

Miscellaneous Payment Terms

Bundling. (Also known as packaging.) Services that are considered subsidiary to another service and not paid separately. For example, payment for an injection on the same day as a physician office visit may be considered "bundled" into the payment for the office visit.

Casemix creep. Occurs when average reported casemix increases without evidence that average actual casemix increased. This may occur because providers fill out certain claim form fields more accurately when payment depends on them. It can also reflect efforts by providers to report higher casemix scores in order to get higher payment.

Outlier. Any patient or case that is unusually expensive. Outlier cases typically receive extra payment.

Prospective payment method. An umbrella term for casemix-adjusted per-episode and per-diem payment methods.

Rebasing. The process by which some payers periodically revisit overall levels of payment to a provider type, especially in comparison with provider costs. It is usually done every few years.

Recalibration. In a prospective payment method, the process by which adjustments are made to relative weights, either annually or every few years.

Usual, Customary and Reasonable (UCR). When payment is made at 100 percent of a provider's charge, many payers check that it is the provider's usual charge for that service, that the charge is (approximately) customary in that area, and that the charge is reasonable for the service provided.

Claims Processing Terms

Allowed amount. (Also known as allowed charge.) The total payment for a service that is "allowed" by a payer. It is typically less than the charge billed by the provider and more than the reimbursement made by the payer.

Charge cap. In a fee schedule or prospective payment method, payment of the lesser of billed charges or the allowed amount otherwise calculated.

Claim vs. line. (Also known as header vs. detail.) Institutional, professional and dental claims all show information at the claim level (e.g., patient name, total charges) and information for particular services at the line level (e.g., procedure, units, charges).

Coinsurance, Coordination of benefits. A percentage of the medical bill (e.g., 20 percent) that a patient is responsible for paying to a provider. When an individual has more than one insurance carrier, claims are reviewed to determine which insurance company is the primary payer.

Copayment. A fixed amount (e.g., \$20 per service) that a patient is responsible for paying to a provider.

Cost sharing. An umbrella term for payments that a patient is responsible for paying to a provider. It comprises deductibles, copayments and coinsurance.

Deductible. The amount a patient must spend out of his or her own pocket in a given time period before the insurer begins making payments. Deductibles are rare in Medicaid programs.

Dually eligible. A client eligible for coverage from both Medicaid and Medicare.

Medicare crossovers. Claims for individuals who are covered by both Medicare and Medicaid, especially when Medicare is the primary payer and Medicaid is the secondary payer.

MMIS – Medicaid Management Information System. The name for the computer systems used by Medicaid programs to adjudicate claims.

Spend-down. (Also known as incurment.) The requirement by which Medicaid recipients who qualify as being “medically needy” must spend their own money on healthcare until they reach the point where they qualify for Medicaid.

TPL – Third-Party Liability. Another entity, often another insurance carrier, that is responsible for all or part of a Medicaid client’s medical bill. Medicaid claims processing systems do not consider Medicare as TPL, so they have separate processing logic for claims with TPL and for Medicare crossover claims.

Reimbursement. Payment from a payer to a provider. Typically, it equals the allowed amount minus TPL minus patient cost-sharing minus spend-down.

Legal and Legislative References

CFR – Code of Federal Regulations. Lists regulations written by CMS and other federal agencies under authority from a statute passed by Congress and signed by the President. (For more information: www.gpo.gov/fdsys.)

Federal Register. Lists proposed and final regulations, as well as notices and other information. It is published each work day. (For more information: www.gpoaccess.gov/fr/index.html.)

HIPAA – Health Insurance Portability and Accountability Act

GAO – U.S. Government Accountability Office. The investigative arm of Congress. It produces many analyses of Medicare and Medicaid payment issues. Formerly known as the General Accounting Office (www.gao.gov/oig).

Social Security Act. This Act was signed into law in 1935; Medicare and Medicaid were created by the Social Security Amendments of 1965. This is the statute that governs Medicare, Medicaid and SCHIP. The statute is available at www.ssa.gov/OP_Home.

Title XVIII. A synonym for Medicare, which was enacted under Title XVIII of the Social Security Act.

Title XIX. A synonym for Medicaid, which was enacted under Title XIX of the Social Security Act.

Organizational References

CMS. The Centers for Medicare & Medicaid Services, an agency of the U.S. Department of Health and Human Services.

Fiscal agent. The contractor used by a Medicaid program to process claims and run the Medicaid Management Information System. The actual scope of work varies by state.

GAO – U.S. Government Accountability Office. The investigative arm of Congress. It produces many analyses of Medicare and Medicaid payment issues. Formerly known as the General Accounting Office (www.gpo.gov/oig).

OIG – Office of the Inspector General. The U.S. Department of Health and Human Services Office of Inspector General protects the integrity of HHS programs and beneficiaries. It produces many reports on Medicare and Medicaid payment issues (oig.hhs.gov).

Medicare contractor. An umbrella term usually comprising companies that process claims on behalf of Medicare.

MACPAC. The Medicaid and CHIP Payment and Access Commission is a federal agency that makes recommendations to Congress, HHS, and the states on issues that affect Medicaid and the Children's Health Insurance Program. It publishes issue briefs and data reports throughout the year (www.macpac.gov).

MedPAC. The Medicare Payment Advisory Commission. A small federal agency that advises Congress on technical and controversial aspects of Medicare payment methods. Its chief products are two useful reports to Congress that are issued in March and June of each year (www.medpac.gov).

QIO. Quality Improvement Organizations. Formerly known as peer review organizations (PROs). Private-sector organizations under contract to Medicare to review the quality and appropriateness of care provided to Medicare beneficiaries. Many QIOs also serve Medicaid programs and other payers.

Contact Us

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*Quinn, Kevin. "The 8 Basic Payment Methods in Health Care." *Annals of Internal Medicine* 163.4 (2015): 300.

